

# Voluntary Group Term Life Insurance Enrollment

Minnesota Life Insurance Company - A Securian Company  
400 Robert Street North • St. Paul, Minnesota 55101-2098

THE OHIO  
STATE  
UNIVERSITY

MINNESOTA LIFE

EMPLOYER NAME: The Ohio State University

POLICY NUMBER: 33909  
OSU

1. If enrolling in VGTLI, complete sections A and D.
2. If you are electing coverage on your dependents, complete sections B and/ or C.
3. Please return completed form to the Office of Human Resources, 1590 N. High St., Suite 300, Columbus, OH 43201.  
Or fax to (614) 292-7813.
4. Visit [hr.osu.edu/benefits](http://hr.osu.edu/benefits) for additional program information, including eligibility and information on determining need for Evidence of Insurability (EOI).
5. To designate a beneficiary, complete a life insurance designation form. Note the employee is the beneficiary of any dependent coverage.

## A. EMPLOYEE INFORMATION

First name	Middle initial	Last name	Employee ID number
Email address			Daytime phone number
Street address	City	State	Zip code
Have you used tobacco in any form during the past twelve months or are you currently using nicotine in any form?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of birth	Date of employment	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	

Life insurance amount requested (not to exceed \$400,000) <sup>1</sup> Completion of EOI is required.

1x salary  2x salary<sup>1</sup>  3x salary<sup>1</sup>  4x salary<sup>1</sup>  5x salary<sup>1</sup>  6x salary<sup>1</sup>  7x salary<sup>1</sup>  8x salary<sup>1</sup>  Waive/Cancel

## B. SPOUSE/SAME-SEX DOMESTIC PARTNER INFORMATION (Affidavit of Same-Sex Domestic Partnership required)

First name	Middle initial	Last name	Daytime phone number
Email address			Daytime phone number
Has your spouse/SSDP used tobacco in any form during the past twelve months or is your spouse/SSDP currently using nicotine in any form?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		
Life insurance amount requested (\$5,000 increments, from \$10,000 to \$150,000) <input type="checkbox"/> \$ _____ <input type="checkbox"/> Waive/Cancel			

## C. CHILDREN INFORMATION (Children are eligible from live birth to age 26)

Life insurance amount requested  
 \$5,000  \$10,000  Waive/Cancel

### Reason For Completing Form

Date of event: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (return form within 31 days of event date)

Qualifying status change (please specify)

- Hired/Newly Eligible  Change in Dependent Eligibility<sup>1</sup>  Birth/Adoption/Legal Guardianship/Legal Custody<sup>1</sup>  
 Open Enrollment  Marriage/Establish SSDP Coverage<sup>2</sup>  Divorce/Dissolution/Termination of SSDP Coverage<sup>1</sup>

Other<sup>1</sup> (describe): \_\_\_\_\_

<sup>1</sup> Documentation required. <sup>2</sup> Affidavit required.

## D. AUTHORIZATION

I have read and understand the materials describing the Voluntary Group Term Life Insurance policy. I certify that the information I have provided in this Enrollment Form is complete and correct. I authorize my employer to make these change(s) and to deduct any premiums from my pay necessary to pay for the life insurance coverage that I have elected above.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Employee signature <b>X</b>	Daytime telephone number	Evening telephone number	Date signed
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